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DATE: August 17, 1998

Document Title: Health Center
Program Expectations

TO: Community Health Centers
Migrant Health Centers
Health Care for the Homeless Grantees
Healthy Schools, Healthy Communities Grantees
Health Services for Residents of Public Housing Grantees
Primary Care Associations
Primary Care Offices

The attached Policy Information Notice (PIN) describes the Bureau of Primary Health Care's expectations for all health center programs covered under section 330 of the Public Health Service Act as amended by the Health Centers Consolidation Act of 1996 (P.L. 104-299).

In addition to requirements for health centers that are specified in law and regulation, Health Center Program Expectations also reflects Bureau priorities and preferences for program funding or aspects of health care programs associated with success. The enclosed Health Center Program Expectations supercedes all previous program expectations issued for Community Health Centers, Migrant Health Centers, Health Care for the Homeless Programs, and Public Housing Health Centers.

If you have any questions regarding the Health Center Program Expectations, please do not hesitate to contact your project officer in your HRSA Field Office.

/ s /

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Assistant Surgeon General
Associate Administrator
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Attachment

BPHC POLICY INFORMATION NOTICE: 98-23

DATE: August 17, 1998

HEALTH CENTER
PROGRAM EXPECTATIONS

Department of Health and Human Service
Health Resources and Services Administration
Bureau of Primary Health Care

*The Mission of the Bureau of Primary Health Care (BPHC)
is to increase access
to comprehensive primary and preventive health care and
to improve the health care status of underserved and
vulnerable populations. The BPHC's Health Center
Program is an essential element in support of the
Mission.*

OVERVIEW

This document describes expectations of entities funded by the Bureau of Primary Health Care (BPHC) under section 330 of the Public Health Service Act as amended by the Health Centers Consolidation Act of 1996. All health centers authorized to receive grants under section 330 are covered by these expectations including community health centers providing care to diverse underserved populations - section 330 (e); those serving migratory and seasonal farm workers and their families - section 330 (g); those serving homeless people including homeless children - section 330 (h); and those serving residents of public housing - section 330 (i). The expectations also apply to school-based health centers funded through the Healthy Schools, Healthy Communities program. Federally Qualified Health Center (FQHC) look-alikes, by definition must meet the requirements for health centers under section 330. Thus, they are governed by these expectations to the same extent as health centers, subject to any waivers. Migrant Voucher Programs are not covered by the expectations.

The term "health center" is used throughout the Program Expectations to refer to all the diverse types of organizations and programs covered by the various subsections of section 330, including organizations funded to serve migrant and seasonal agricultural workers, the homeless, and residents of public housing. The expectations emphasize the similarities but recognize the differences among health centers. There is no "model" health center, yet all health centers share many attributes including: their mission to provide primary and preventive health services to underserved populations, while working with constrained resources; the imperative to maintain strong leadership, finances and infrastructure in order to adapt and survive the challenges of a transforming health care environment; and the delivery of high quality clinical services which have a demonstrated impact on health outcomes. Health centers have been a critical component of our country's health care safety net for more than 30 years and will continue to be essential for the foreseeable future. The Program Expectations are intended to ensure that health centers not only survive but thrive as they move into the twenty-first century.

The Program Expectations recognize that health centers serve culturally and linguistically diverse populations. Some health centers receive funding for the specific purpose of providing services to a distinct underserved population such as homeless people, migratory and seasonal farmworkers, or residents of public housing. The expectations state that all health centers must provide services which are culturally and linguistically appropriate for the diverse populations they serve. Health centers which receive funding to serve a defined special population, however, have additional requirements they must meet, and these are identified in the expectations.

The Program Expectations address requirements of law and regulation as well as BPHC policies. In general, expectations which have a basis in law¹ and regulation² are indicated in the document by the word "must" and must be met for entities to be eligible for funds. Expectations that reflect BPHC priorities and preferences for program funding or elements associated with successful programs are referred to by "should" or similar wording. In evaluating new and continued funding applications, consideration will be given to the extent to which applicants comply with those expectations identified by "should". Most importantly, the expectations highlight aspects of health center programs associated with success.

The Program Expectations provide the basis for other BPHC processes and documents including the grant application instructions, grant review criteria, and program reviews

¹Section 330 of the Public Health Service Act (PHS), as amended by Public Law 104-299, the Health Centers Consolidation Act of 1996

²42 CFR Part 51c and 42 CFR Part 56. These regulations apply only to health centers funded under sections 330(e) and 330(g) of the PHS Act, respectively. While health center programs funded to serve homeless people or residents of public housing are not bound by these regulations, these programs may wish to look to these regulations for guidance. Where new provisions of the Health Centers Consolidation Act of 1996 conflict with requirements specified in the regulations, the provisions of the Act take precedence.

including the Primary Care Effectiveness Review (PCER). Policy Information Notices (PIN) and Program Assistance Letters (PAL), which are issued periodically by the Bureau, provide additional detail and guidance on selected topics addressed in the expectations. In addition, these expectations may be supplemented for classes of health centers whose unique organizational/operational style demand that the expectations be adapted to their way of doing business (i.e., school-based health centers).

The Program Expectations are comprised of four sections. Section I., "Mission and Strategy" addresses the importance of adapting to health care trends and remaining financially viable, while fulfilling the essential health center mission of providing preventive and primary care services which improve the health Section II., "Clinical Program" highlights the services, staffing and systems which contribute to the provision of high quality health care. Section III., "Governance" summarizes the structure, composition and responsibilities of health center governing bodies. Section IV., "Management and Finance" describes the management team, systems and infrastructure which lead and support the health center in the pursuance of its mission. Because all components work together to make a health center successful, the Program Expectations should be reviewed in their entirety. However, a table of contents is provided to assist with reference to a particular section.

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I. MISSION AND STRATEGY

A. EXPECTATION

In order to fulfill the health centers' mission of improving the health status of underserved populations, health centers must continue to survive and thrive through health care reforms, marketplace changes and advances in clinical care. Health centers must assess the needs of underserved populations and design programs and services which are culturally and linguistically appropriate to those populations. They must measure the effectiveness and quality of their services and continuously evolve their programs to achieve the greatest impact. They must operate as efficiently as possible. Health centers must collaborate with other organizations, at the same time maintaining their integrity as federally-funded health centers by continuing to fulfill their mission, and complying with applicable law, regulation and expectations.

B. EXPLANATION

1. Underserved Populations

Federally funded health centers provide health services to underserved populations. This includes all people who face barriers in accessing services because they have difficulty paying for services, because they have language or cultural differences, or because there is an insufficient number of health professionals/resources available in their community. Underserved populations also include people who have disparities in their health status. Some health centers may focus on specific special populations such as homeless people, migratory and seasonal farmworkers, residents of public housing, or at-risk school children, while most serve a cross-section of the population in their communities. The specific population groups to be served by a health center are defined by that health center through a process of assessing the needs, resources and priorities in their community.

For many health centers, the need for services far exceeds available resources. Health centers are faced with extremely difficult choices regarding which underserved population groups to serve and/or which needed services to provide. An inclusive and informed planning process frames the decisions every health center must make.

2. Cultural Competency

Health centers serve culturally and linguistically diverse communities and many serve multiple cultures within one center. Although race and ethnicity are often thought to be dominant elements of culture, health centers should embrace a broader definition to include language, gender, socio-economic status, sexual orientation, physical and mental capacity, age, religion, housing status, and regional differences. Organizational behaviors, practices, attitudes, and policies across all health center functions must respect and respond to the cultural diversity of communities and clients served. Health centers should develop systems that ensure participation of the diverse cultures in their community, including participation of persons with limited English-speaking ability, in programs offered by the health center. Health centers should also hire culturally and linguistically appropriate staff.

3. Strategic Positioning

Significant changes are occurring throughout the country in the way in which health care is being financed and delivered. Health centers need to understand their health care marketplace and be willing and able to adapt and reposition themselves to survive. Understanding the health care marketplace requires looking beyond the health center's service area to what is occurring with key players in the larger marketplace and identifying opportunities and challenges for health centers.

a. Planning

In order to succeed, health centers must engage in active, ongoing planning processes. Planning should include both long term strategic planning and annual operational planning. Strategic planning should establish long term strategic goals. Operational planning focuses on short-term objectives within the context of the strategic plan.

Planning should be based on collecting and analyzing data, as well as on input from diverse stakeholders: health center governing board members, staff at all levels, community members, clients and organizations involved in providing or paying for health care in the marketplace. Recipients of funding to provide services to residents of public housing must consult with residents as part of their planning and grant application processes.

Planning should include ongoing evaluation, feedback and adjustment based on environmental, operational, or clinical change. While remaining flexible and allowing for response to new opportunities and pressures, plans should describe the health center's goals and priorities sufficiently to guide members of the organization in strategic and operational decision-making.

b. Collaboration and Affiliation

Health centers must collaborate appropriately with other health care and social service providers in their area. Such collaboration is critical to ensuring the effective use of limited health center resources, providing a comprehensive array of services for clients, and gaining access to critical assistance and support (e.g. housing, food, jobs). In many instances, health centers may consider more formal affiliation opportunities such as contractual relationships, certain types of joint ventures or mergers. Affiliations are desirable when they lead to integrated systems of care which strengthen the safety net for underserved clients.

Health centers may join other organizations such as other health centers, hospitals, specialty groups and social service providers to form integrated delivery systems. An integrated system may be formed through contractual relationships or memoranda of agreement. In these situations, each partner in the affiliation retains its organizational autonomy and integrity and the health center governing board continues to meet expectations. In other situations, a new organization may be formed.

While health centers are encouraged to collaborate with other entities, they must ensure that all the laws, regulations and expectations regarding the health center governing board member selection, composition, functions and responsibilities are protected if the health center wants to retain eligibility for federal funding. The resulting delivery system must contribute

to the desired outcomes of availability, accessibility, quality, comprehensiveness, and coordination.

c. Cost-effectiveness/cost-competitiveness

Many decisions in the health care arena are being driven by economic considerations, and it is imperative that health centers strive to be cost-competitive. All health centers must be as efficient as possible, understand the costs of the services they provide, and bring costs in line with other providers in the marketplace providing comparable services. Health centers should be able to document the value, i.e., cost and quality, of the services they provide and demonstrate the impact of their services on the health and well-being of the communities they serve.

As part of becoming cost effective, health centers are expected to evaluate their management and delivery systems in order to be able to increase efficiency and to maintain operations in the competitive, cost conscious marketplace. Health centers will need to manage the care of their patients in accordance with their managed care risk arrangements and be able to monitor their financial risk related to managed care contracting requirements.

4. Needs Assessment

a. Understanding Community Needs and Resources

Crafting strategy demands a thorough knowledge of the community and population groups a health center intends to serve. In order to use limited resources effectively, this requires both an understanding of the health care needs of the target community, as well as resources available to meet those needs. Needs and available resources should be monitored on an ongoing basis and comprehensively assessed on a periodic basis, or when environmental changes dictate reassessment.

Although there is no prescribed way to conduct a needs assessment, each program should be able to describe: 1) the geographic area and/or population groups which constitute their principal target population; 2) the characteristics of this population in terms of age, sex, socioeconomic status, health insurance status, ethnicity/culture, language, health status, housing status and health care utilization patterns; 3) perceptions of the target population about their own health care needs and barriers to accessing needed services; 4) other providers of health and social services accessible to the

population; and 5) gaps in services that the health center proposes to address.

b. Description of Current and Potential Users of Services

All needs assessments should examine both people currently using services and those in the target population who are not using needed services. In order for health centers to be able to document their achievement of health care outcome goals, health centers should be able to describe their current clients in terms of demographics, utilization patterns and health care status. Health centers should not lose sight of people in their target population who are not using needed services. Sometimes, they have the greatest health needs and require extra effort to bring into care.

c. Special Populations

All health centers serve diverse populations and must understand the differing needs of these populations. Some health centers receive federal funding designated to serve special medically underserved populations including homeless people, migratory and seasonal farmworkers and their families, at-risk school children, or residents of public housing. For those health centers receiving federal funding to serve homeless people, these funds may be used to provide services to formerly homeless people for up to twelve months after housing has been obtained. Programs receiving federal funding to serve special populations must specifically assess needs and resources for these populations. Federal grant funds may not be used to supplant other funds or in-kind contributions from state and local sources for centers serving homeless people or residents of public housing.

Health centers also serve populations with specific health needs such as those related to HIV, pregnancy, mental health or substance abuse. All health centers must be able to provide or arrange for a full spectrum of primary care services. Health centers serving large numbers of individuals with a particular health care need should specifically assess service needs, develop outcome and services goals, and provide or arrange for access to needed services.

5. Continuous Quality Improvement and Performance Measurement

Performance measurement and quality improvement are critical elements for excellence in the health care industry. The environment is driving the use of data to increase accountability, support quality improvement, facilitate and

support clinical decisions, monitor the population's health status, empower patients and families to make informed health care decisions, and provide evidence to eliminate wasteful practices. Similarly, both federal and state governments are requiring programs to document performance and improvement as a condition of continued support. All health centers must have a quality improvement system that includes both clinical services and management.

Quality depends upon the health center's commitment to its community and its dedication to quality improvement. Quality of health center services also requires effective clinical and administrative leadership and functioning clinical and administrative systems. The organization should support and establish a locus of responsibility, such as an interdisciplinary quality improvement committee, for the quality improvement program. Quality improvement activities and results should be reported to the clinical and management staff as well as the governing board.

Health center quality improvement systems should have the capacity to examine topics such as patient satisfaction and access; quality of clinical care; quality of the work force and work environment; cost and productivity; and health status outcomes. In addition, quality improvement systems should have the capacity to measure performance using standard performance measures and accepted scientific approaches. Centers are encouraged to establish performance standards in concert with other health centers serving similar populations. In analyzing performance data, health centers should compare their results with other comparable providers at the state and national level, and set realistic goals for improvement. Periodic reassessment enables health centers to measure progress toward these improvement goals and respond to advances or changes in clinical care. Since successful utilization management is an effective means of delivering appropriate services and maximizing value, quality improvement studies addressing utilization management of appropriate specialty, pharmacy, hospital and other services is key.

II. CLINICAL PROGRAM

A. EXPECTATION

Improving health status among underserved populations is the ultimate goal of health center programs. Health centers must have a system of care that ensures access to primary and preventive services, and facilitates access to comprehensive health and social services. Services must be responsive to the needs and culture of the target community and/or populations. Quality of health center services is paramount. Health centers must have effective clinical and administrative leadership, systems and procedures to guide the provision of services, and ongoing quality improvement programs to ensure continuous performance improvement.

B. EXPLANATION

1. The System of Care

a. Required Services

Health centers must provide required health care services as described in statute and regulation. All health center programs must provide, directly or through contracts or cooperative arrangements, basic health services including: primary care; diagnostic laboratory and radiologic services; preventive services including prenatal and perinatal services; cancer and other disease screening; well child services; immunizations against vaccine-preventable diseases; screening for elevated blood lead levels, communicable diseases and cholesterol; eye, ear and dental screening for children; family planning services and preventive dental services; emergency medical and dental services; and pharmaceutical services as appropriate to a particular health center.

All health centers must also provide services which help ensure access to these basic health services as well as facilitate access to comprehensive health and social services. Specifically, health centers must provide: case management services; services to assist the health center's patients gain financial support for health and social services; referrals to

other providers of medical and health-related services including

substance abuse and mental health services; services that enable patients to access health center services such as outreach, transportation and interpretive services; and education of patients and the community regarding the availability and appropriate use of health services.

Programs receiving funding to serve homeless individuals and families also must provide substance abuse services. Substance abuse services include treatment for alcohol and/or drug abuse and may use a variety of treatment modalities such as: non-hospital and social detoxification, non-hospital residential treatment and case management and counseling support in the community. While these service requirements are specific to programs receiving funding for this special population, all health centers are encouraged to ensure access to these services for all their patients.

Required services may be provided by health center staff or through defined arrangements with other individuals or organizations. When a required service is not provided directly by health center staff, written agreements should be developed specifying how the service is provided.

b. Additional Services

Additional services may be critical to improve the health status of a specific community or population group. For example, health centers serving migratory and seasonal farmworkers should provide programs which reduce environmental and occupational risks for farm workers. Migrant health centers should be knowledgeable of the Environmental Protection Agency's Worker Protection Standard and other pesticide safety regulations. A program serving homeless people may decide that the provision of mental health services is critical to the effective provision of primary care. Services beyond the required health center services should be provided based on the needs and priorities of the community, the availability of other resources to meet those needs and the resources of the health center.

c. Hospitalization and Continuum of Care

The focus of health center services is primary and preventive care. However, all health centers are expected to assess the full health care needs of their target populations, form a comprehensive system of care incorporating appropriate health and social services, and manage the care of their patients throughout the system.

All health centers must have ongoing referral arrangements with one or more hospitals. Health center clinicians should obtain admitting privileges and hospital staff membership at their referral hospital(s) so health center patients can be followed by health center clinicians. When this is not possible, the health center must have firmly established arrangements for hospitalization, discharge planning and patient tracking.

The health center should assure that quality specialty medical, diagnostic and therapeutic services are available to patients through a system of organized referral arrangements. The effectiveness of these referral arrangements depends on timely exchange of information about the patients between the specialists and health center clinicians. Health centers should consider forming or joining integrated delivery systems to gain improved access to hospital and other services for their patients.

d. After-Hours Coverage

The provision of comprehensive and continuous care includes care during hours in which the health center is closed. Although specific arrangements for after-hours coverage vary by community, all health centers should establish firm arrangements for after hours coverage. Wherever possible, coverage should include the health center clinicians and may also include other community clinicians. At a minimum, the coverage system should ensure telephone access to the covering clinician, have established mechanisms for patients needing care to be seen in an appropriate location, and assure timely follow-up by health center clinicians for patients seen after-hours. Health centers should consider the linguistic needs of their patients when designing their after-hours coverage system.

2. Service Delivery Models

Health centers serve diverse populations, have differing levels of resources and varying marketplace dynamics. This variety has led to a range of service delivery models. Health centers vary across many characteristics including location and hours of services, mix of services and type of staff providing services.

Location: Health centers must provide services at locations and times that ensure services are accessible to the community being served. Health center governing boards are responsible for deciding on the locations and times services are available. Many

health centers operate primarily fixed-site locations. Others offer services in locations ranging from homeless shelters to migrant farmworker camps to public housing communities to schools. Some use vans to bring specific services to a broad audience or reach a highly mobile population. Many operate from several locations, including off-site locations. Programs serving people who are homeless or mobile engage in extensive outreach to provide services wherever the patients are.

Hours: A health center's hours of operation should facilitate access to services and should include some early morning, evening and/or weekend hours. Health centers should also provide for access to needed care when the health center is closed.

Mix of services: The specific mix of services offered by health centers is influenced by demographic, epidemiological, resource and marketplace factors. For example, health centers serving a population that is primarily women of child-bearing age and young children will offer services appropriate to those populations. In contrast, health centers serving primarily adult men will focus their services on the needs of that population. Communities with high prevalence of certain health problems (e.g., tuberculosis, HIV, diabetes, hypertension, mental illness, substance abuse) should design their mix of services to best address those issues.

Type of service provider: The types of service providers utilized by health centers will depend on the mix of services the health center offers. Many health centers benefit from an interdisciplinary team of providers. As appropriate, health centers should utilize various disciplines and levels of providers. Physicians, physician assistants, nurse practitioners and nurse midwives, as well as staff skilled in providing mental health, social work and substance abuse services may all be part of the provider team. Programs may also select staff members who are members of the community to provide education and outreach services.

3. Contracting for Health Services

Health centers may have contracts or other types of agreements to secure services for health center patients that it does not provide directly. The service delivery arrangement must contribute to the desired outcomes of availability, accessibility, quality, comprehensiveness, and coordination. Arrangements for the provision of services that the grantee

organization provides through a subcontractor should be in writing and clearly state: the time period during which the agreement is in effect; the specific services it covers; any special conditions under which the services are to be provided; and the terms and mechanisms for billing and payment. Other areas that should be addressed in the written agreement include but are not limited to: credentialing of contracted service providers; the extent to which the contracted services and/or providers are subject to the health center's quality improvement and risk management guidelines and requirements; and any data reporting requirements.

4. Health Care Planning

In order to ensure that human and financial resources are being applied in the most effective and efficient way possible to improve the health status of the community and meet the community's identified needs, each health center must develop health care goals and objectives as part of the organization's planning process. The health care goals and objectives should address the highest priority health care needs of the community served and consider both the role of the health center in the community's system of care and the specific actions the health center will undertake on behalf of its patients and the community. The objectives and action steps should be specific, reasonable, measurable and achievable. Collaboration and affiliations with other agencies and providers should be utilized to achieve health care goals when possible.

5. Clinical Staff

The composition and structure of a health center's clinical staff are central to the health center's ability to provide high quality care and assure continuity of care for its patients. All health centers are expected, through aggressive recruitment and retention, to maintain a core staff of primary care clinicians with training and experience appropriate to the culture and identified needs of the community.

a. Leadership

Strong clinical leadership is essential for all health centers. Health centers should have a Clinical Director with training and skills in leadership and management who works closely with other members of the health center's management team. Typically, the Clinical Director is a physician, although other types of clinicians may fulfill the role, particularly in very small programs which may be staffed by non-physicians. In some marketplaces, a physician Clinical Director may be essential to effectively position the health center.

Clinical Directors are expected to: 1) provide leadership and management for all health center clinicians whether employees, contractors or volunteers; 2) work as an integral part of the management team; and 3) establish, strengthen and negotiate relationships between the health center and other clinicians, provider organizations and payers in its marketplace.

Because it is critical that the Clinical Director always represent the interests of the health center, its patients and the community it serves, it is preferred that a health center directly employ its Clinical Director. If this individual is not directly employed, the Chief Executive should retain authority to select and dismiss the individual.

b. Staffing

Clinical staffing patterns vary among health centers. All staffing arrangements must lead to the desired outcomes of availability, accessibility, quality, comprehensiveness and coordination of services for health center patients. Physician staff should be board certified or residency trained. Other clinicians should be licensed and certified as appropriate under state law.

It is preferred that the health center directly employ its core clinical staff (at least the majority of the health center's providers). If the core staff are not directly employed, then the Chief Executive Officer should retain the authority to select and dismiss individual providers. Also, except in very small health centers or certain special population programs, it is expected that the employed core staff work only for the health center. Staff who work for the health center on a contract or volunteer basis may augment the employed core staff as appropriate.

The recruitment and retention of high quality health professionals are the foundation of a successful health center and require a multi-faceted approach. Health center systems and policies should support clinicians with the tools and systems appropriate for quality care, including high patient satisfaction. Management based collaboration, work structured to be meaningful and challenging, as well as a commitment to share information and ensure participation in decision-making are key strategies for a stable and productive staff committed to the mission and future of the health center.

A fair compensation and benefit package also supports long-term retention, and enhances productivity and quality. Appropriate incentive plans and deferred compensation plans which

are compatible with fiscal resources, the health center mission and management philosophy, and are in accord with state and federal laws, should be explored as methods to maximize the retention of productive, quality and committed health professionals.

c. Credentialing and Privileging

The health center should define standards for assessing training, experience and competence of clinical staff in order to assure the clinicians' ability to qualify for hospital privileges and payer credentialing. Credentialing should follow a formal process which includes querying the National Practitioner Data Bank and verifying education and licenses. Credentialing and privileging processes should meet the standards of national accrediting agencies such as the Joint Commission on Accreditation of Health Care Organizations (JCAHO) and the Accreditation Association for Ambulatory Health Care, Inc., (AAHC) as well as requirements for coverage under the Federal Tort Claims Act (FTCA). Quality assurance findings should be specifically considered in ongoing credentialing of clinical staff.

d. Continuing Professional Education

Continuing professional education (CPE) is critical to the provision of quality care. Health centers are expected to ensure access to CPE that maintains licensure of the provider and is appropriate to the needs of each health center, its staff and the community served.

e. Affiliation with Teaching Programs

When appropriate, health centers are encouraged to develop affiliations with clinical training programs. The purpose of successful affiliations should be to contribute to the mission and objectives of the health center, to meet the educational objectives of health professionals in training and to increase understanding of the health care needs of underserved populations. Health centers making the decision to develop teaching affiliations are encouraged to seek compensation for the costs of training provided.

6. Consumer Bill of Rights and Responsibilities

With the health system in a state of continual change, the rights and responsibilities of people using the health services, especially underserved and minority populations, need to be reaffirmed. Therefore, health centers should implement a

Consumer Bill of Rights and Responsibilities: 1) to strengthen consumer confidence in health centers and a health care system that is fair, responsive and accountable to consumer concerns; 2) to encourage consumers to take an active role in improving their health; 3) to strengthen the strong relationship between patients and health care professionals; and 4) to reinforce the critical role consumers play in safeguarding their own health. Health centers should review the Consumer Bill of Rights and Responsibilities established by the Advisory Commission on Consumer Protection and Quality in the Health Care Industry and adopt and implement the precepts applicable to their operations.

7. Clinical Systems and Procedures

a. Policies and Procedures

Health centers must have written policies and procedures which address at least the following elements: hours of operation; patient referral and tracking systems; the use of clinical protocols; risk management procedures; procedures for assessing patient satisfaction; consumer bill of rights; and, patient grievance procedures. Health center clinical protocols should reflect the current guidelines established by health agencies or professional organizations such as the Agency for Health Care Policy and Research, the American College of Obstetrics and Gynecology, the Advisory Committee on Immunization Practices, etc.. Health centers intending to seek accreditation should ensure that their policies and procedures address all the elements expected by the accrediting agency.

b. Clinical Systems

Patient flow and appointment systems should foster access and continuity of care, and minimizing waiting time and "no-shows." Patient flow and appointment systems should also provide for emergent problems and call-in or walk-in patients.

A clinical information system centered around a medical record must be in place. Confidentiality of records and data must be protected at all levels. The health center should utilize a medical records system that promotes thorough documentation and quality of care such as the Problem Oriented Medical Record (POMR) and uses flow sheets and recording forms when appropriate.

A clinical system which incorporates recall for routine preventive services and chronic disease management, and a system that allows tracking of patients who are referred to specialists and other off-site services, require x-ray or lab, or who are hospitalized, are essential to a quality program. The clinical information system feeds data and information into the health

center's quality improvement program.

III. GOVERNANCE

A. EXPECTATION

Governance by and for the people served is an essential and distinguishing element of the health center program. Except as noted below, health centers must have a governing body which assumes full authority and oversight responsibility for the health center. The governing board must maintain an acceptable size, composition and meeting schedule. Strategic thinking and planning are essential functions for the board within the context of the environment in which the health center operates, as well as pursuing its mission, goals and operating plan. The board carries out its legal and fiduciary responsibility by providing policy level leadership and by monitoring and evaluating the health center's performance.

B. EXPLANATION

1. Overview of Requirements

Governance requirements for health centers are addressed in law, regulation and policies. Requirements in the law apply to all health centers. The regulations set forth in 42 CFR Part 51c and 42 CFR Part 56 apply only to community health centers and migrant health centers respectively, though they provide useful guidance for other types of health centers. Section 330 requires that the health center has a governing body which: is composed of individuals, a majority of whom are being served by the center and who, as a group, represent the individuals being served by the center; meets at least once a month; schedules the services to be provided by the center; schedules the hours during which services will be provided; approves the center's grant application and annual budget; approves the selection of the director for the center; and except in the case of public entities, establishes general policy for the center.

2. Board Composition

a. Consumer Board Members

Health center governing boards are comprised of individuals who volunteer their time and energy to create a fiscally and

managerially strong organization for the purpose of improving the

health status of their communities. A majority of members of the board must be people who are served by the health center and who, as a group, represent the individuals being served.

Health center programs that have had the consumer majority requirement waived by the Secretary are still expected to meet the intent of the legislation of ensuring strong consumer input into the policies of the health center program. In these situations consumer input may be achieved in varying ways such as through formal advisory boards, regularly constituted focus groups, or by including persons who have previously been consumers but no longer meet the special population definition.

Since the intent is for consumer board members to give substantive input into the health center's strategic direction and policy, these members should utilize the health center as their principal source of primary health care. A consumer member should have used the health center services within the last two years. A legal guardian of a consumer who is a dependent child or adult, or a legal sponsor of an immigrant, may also be considered a consumer for purposes of board representation.

Additionally, as a group, consumer members of the board must reasonably represent the individuals served by the health center in terms of race, ethnicity, and gender. When a health center receives BPHC funding solely to support the delivery of services to a special population (homeless, migratory or seasonal farmworkers, residents of public housing or at-risk school children) the consumer majority must come from the target group, unless a waiver has been granted. When a health center receives both community health center funding and funding designated for a special population, representation should be reasonably proportional to the percentage of consumers the special population group represents. However, there should be at least one representative from the special population group. The intent is not to impose quotas on board membership but to ensure that boards are sensitive to the needs of all health center consumers.

b. Other Board Members

Since health centers are complex organizations working in dynamic environments, the board should be comprised of members with a broad range of skills and expertise. Finance, legal affairs, business, health, managed care, social services, labor relations and government are some examples of the areas of expertise needed by the board to fulfill its responsibilities. Regulations for community and migrant health centers place limitations on the percent of non-consumer members who represent

the health care industry. No more than half (two-thirds for migrant health centers) of the non-consumer representatives may derive more than 10% of their annual income from the health care industry. All health centers should strive for diversity of expertise and perspective among their board members.

c. Number of Members

The number of board members must be specified in the bylaws of the organization. The bylaws may define a specific number or provide a limited range if there are reasons for not maintaining a specific number of members. The size should be related to the complexity of the organization and the diversity of the community served.

Regulations for community and migrant health centers specify boards must have at least 9 and no more than 25 members. These size parameters are designed to ensure a large enough board to achieve diverse representation across the consumer groups and expertise while maintaining a size that effectively functions and makes decisions.

d. Selection of Board Members

The organization's bylaws or other internal governing rules must specify the process for board member selection. The bylaws should specify the number of terms a member may serve and provide for regular election of officers and periodic changes in board leadership.

e. Conflict of Interest

The organization's bylaws or written corporate board-approved policy must include provisions that prohibit conflict of interest or the appearance of conflict of interest by board members, employees, consultants and those who furnish goods or services to the health center. No board members shall be an employee of the health center or an immediate family member of an employee. The Chief Executive may serve as ex-officio member of the board.

3. Governing Board Functions and Responsibilities

The governing board of a health center provides leadership and guidance in support of the health center's mission. The board is legally responsible for ensuring that the health center is operating in accordance with applicable federal, state and local laws and regulations and is financially viable. Day-to-day leadership and management responsibility rests with staff under

the direction of the chief executive or Program Director.

a. Bylaws

Bylaws which are approved by the health center's governing board must be established. The bylaws should be reviewed and modified as necessary to remain current. At a minimum, health center bylaws should address: the health center's mission; membership (size, composition, responsibilities, terms of office and selection/removal processes); officers (responsibilities, terms of office, selection/removal processes); committees (standing, ad-hoc, membership and responsibilities); meeting schedule, quorum and acceptable meeting venues; recording, distribution and storage of minutes; and provisions regarding conflict of interest, executive session and dissolution.

b. Responsibilities

A governing board is responsible for assuring that the health center survives in its marketplace while it pursues its mission. This is a massive challenge in an extremely dynamic health care environment which is placing increasing financial and service delivery pressures on all providers. Boards must be knowledgeable about marketplace trends and be willing to adapt their policies and position to reflect these trends. In addition to approving annual grant applications, plans, and budgets, boards should work with health center management and community leaders to actively engage in long-term strategic planning to position the health center for the future.

Success is dependent on the health center's ability to effectively adapt to marketplace trends while remaining financially viable. Boards must not only plan effectively but also measure and evaluate the health center's progress in meeting its annual and long-term programmatic and financial goals. The health center's mission, goals, and plans should be revised as appropriate to the feedback gained through the evaluation process.

The governing board must select the services provided by the health center. While certain services are mandated by law, health center boards have a great deal of latitude in deciding which additional services should be offered by the health center and whether the services should be offered directly or through referral and collaboration with other service providers. Resources are always limited and a major challenge confronting health center boards is deciding which services should be supported with available resources. Effective needs assessment and planning processes are essential for making informed

decisions about service configuration.

The governing board must determine the hours during which services are provided at health center sites. Health centers are expected to schedule hours that are appropriate for their community. Generally this means some early morning, evening and/or weekend hours should be offered to accommodate people who cannot easily access services during normal business hours.

The board must approve the annual budget and grant application. The intent is not that the board simply sign-off on documents but that it understands the substance and implications of the budget and application. Ensuring the financial health of the organization and aligning the goals of the project application with the strategic direction of the health center are critical functions for the board. In order to effectively fulfill these functions, the board must be involved in health center planning throughout the year.

The board must approve the selection and dismissal of the chief executive or Program Director of the health center. Because the chief executive is the primary connection between board established policy and health center operations, the board must evaluate the performance of the chief executive and hold him or her accountable for the performance of the health center. Together, the board, the chief executive and other members of the management team comprise the leadership for the health center. To succeed, they must work together to ensure a strong organization and move forward into the future.

Except in the case of public entities funded under section 330(e), the board must establish general policies for the health center. These include personnel, health care, fiscal, and quality assurance/improvement policies. These policies provide the framework under which health center staff conduct the day-to-day operations of the organization.

c. Board Meetings

Health center governing boards must meet at least monthly. Where geography or other circumstances make monthly, in-person meetings burdensome, the meetings may be held by telephone or other means of electronic communication.

The board must keep minutes of each meeting which are approved at a subsequent meeting. The board should also maintain a systematic tracking system of approval/disapproval of board policies and procedures as well as other records to verify and document its functioning.

d. Board training and development

It is expected that governing board members have sufficient knowledge and information to make informed decisions about the health center's strategic direction, policies and financial position. Board members should be provided with opportunities for training and development, as well as conducting self evaluations. The board is responsible for identifying and assuring it meets its educational and training needs including orientation and training of new board members.

e. Committees

The board should have a committee structure which facilitates carrying out its responsibilities. Appropriate committees may include executive, finance, quality improvement, personnel, and planning. However, only the executive committee should be authorized to act for the Board.

4. Exceptions

a. Waivers for Special Population Health Centers

The law permits the Secretary to grant waivers for all or part of the requirements, for good cause, for health centers serving special populations; those serving migratory and seasonal farmworkers and their families - section 330(g); those serving homeless people including homeless children - section 330(h); and those serving residents of public housing - section 330(i). Health centers requesting waivers for all or any governance requirement must provide a compelling argument as to why the program cannot meet the statutory requirement, as well as alternative strategies detailing how the program intends to meet the intent of the law. Community health centers funded under the authority of section 330 (e), with or without funding for a special population program, are not eligible for a waiver of any part of the governance requirements.

b. Public Entities

Community health centers funded under section 330(e) of the Act that are sponsored by public entities, such as health departments, public hospitals, public universities, etc., may meet the governing board requirements in one of two ways. The public entity's board may meet health center board composition requirements including having a consumer majority. In this case, no special considerations are needed. When the public entity's board does not meet health center composition requirements, a

separate health center governing board must be established. The health center board must meet all the selection and composition requirements and perform all the responsibilities expected of governing boards except that the public entity may retain the responsibility of establishing fiscal and personnel policies. The health center board should be a formally incorporated entity and it and the public entity board are co-applicants for the health center program. When there are two boards, each board's responsibilities must be specified in writing so that the responsibilities for carrying out the governance functions are clearly understood.

c. Tribal Entities

There is no governing board requirement for health centers operated by an Indian tribe or tribal or Indian organization under the Indian Self-Determination Act or an urban Indian organization under the Indian Health Care Improvement Act.

5. Network Grantees

Health centers are forming and participating in networks for many purposes. In most cases, participating health centers retain their own governing boards and these boards continue to be subject to applicable law, regulation and expectations. When health centers come together in a network, and the network is a section 330(e) grantee, with the health centers operating as sub-recipients, the governing board at the network level, must meet the governing board requirements and expectations. Furthermore, the network must have sufficient staff and other resources to ensure the network board carries out its functions.

6. Affiliations

In some organizational affiliations, the selection, composition and/or responsibilities of the health center governing board may be altered. This may happen through formation of a new board for an integrated delivery system or through the participation of affiliate representatives on health center boards. There may also be various arrangements where a portion of the scope of the project is being provided by an entity other than the grantee. With any such arrangement the governing board must retain its full authorities, meet selection and compositional requirements and exercise all responsibilities and functions prescribed in legislation and regulations.

IV. MANAGEMENT AND FINANCE

A. EXPECTATION

A strong management team is essential to health center success. The management team must work with the governing board, leading organizational changes to adapt to marketplace trends. Health center management must operationalize the health center's mission and strategic objectives. They must do this within available resources ensuring that the health center is financially viable and cost-competitive. Health center management must be supported by strong personnel, financial, information, and clinical systems.

B. EXPLANATION

1. Management Staff and Structure

a. Relationship of Management Staff to Board

The health center should have a line of authority from the board to a chief executive (President, Chief Executive Officer - Chief Executive, Executive Director, Project Director) who delegates as appropriate to other management and professional staff. As head of the management team, the Chief Executive should have the authority, responsibility and skills to: communicate with the board and management team; operationalize board policies; manage personnel and systems; allocate resources and operate within available resources; identify and resolve problems; interact with the community and providers and payers in the marketplace; respond to opportunities and; plan for future events. The Chief Executive is accountable to board-established long-term goals and operating plans.

The governing board must select, dismiss and directly employ the Chief Executive or director of the health center. It is preferred that other key management staff and core primary care provider staff also be directly employed by the health center. However, a grant recipient may contract for or enter into other arrangements for these positions. In all arrangements, the Chief Executive must be given an appropriate level of authority to lead and manage the health center, and should have full control over selecting and dismissing all staff assigned to the Health Center.

The demands of leading a health center usually require a health center to employ a full-time Chief Executive. In some

instances, however, the director functions may be performed in combination with other responsibilities. For example, small health centers may employ one person who fulfills the Director function along with financial or clinical management functions.

An organization that operates other lines of business related to and supportive of the health center may have a Chief Executive who is responsible for overall corporate management and effectively works part-time on other health center activities and part-time on activities of the organization.

b. Management Team

The quality of the management team is a critical predictor of health center success. Recruitment and retention of management staff should be a health center priority.

Health centers are most effectively managed by a team of individuals with the skills to provide leadership, fiscal management, clinical direction and management information system expertise. The management team usually consists of a Chief Executive or Program Director in lead of a team that includes a Clinical Director, Chief Financial Officer, and a Chief Information Officer. The functions associated with these positions may be combined and performed by one or more individuals, as appropriate. In larger health centers, additional management staff may be part of the management team. In situations where the health center is collaborating with other health centers in its marketplace, some of these positions may be shared. Management training and expertise is desirable for all members of the management team, and is essential for the Executive and Clinical Directors.

Position descriptions and an organizational chart reflecting these functions and their relationships should be maintained by management and provided to the board. It is critical that the organizational structure and processes facilitate a team approach to management.

c. Staff Development

The health center should have an active plan for recruitment and retention of all staff, including volunteers. All staff should be qualified by training and/or experience for their scope of duty. Positions that require licensure must be filled by appropriately licensed professionals. Position descriptions should be developed for all staff. The descriptions should include professional and interpersonal skills that will ensure staff fulfill their responsibilities within the language and cultural context of the area.

A staff development program should be developed for all staff to improve skills critical to health center success. Staff in management positions should have and maintain leadership skills. Continuing professional education is critical to the provision of quality care. All appropriate staff must receive training to maintain licensure and meet regulatory requirements such as Occupational and Safety Health Administration (OSHA) and Clinical Laboratory Improvement Amendments (CLIA).

2. Management Role in Planning and Strategic Positioning

All members of the management team play a key role in strategic and operational planning. The team should work closely with board, community members and other providers and payers in the marketplace to provide leadership in shaping the health center's strategy. The management team is most familiar with the health center's internal capabilities and constraints, and they provide a critical perspective to the planning process. Health center management is also responsible for assessing progress and providing critical information to the Board for revising the health center's strategic direction.

The health center's annual operating plan is developed by health center staff under the direction of the management team. The plan reflects the board's established mission and goals and guides management in day-to-day decision-making. The operating plan is approved by the board and is monitored and adjusted throughout the year by health center management.

3. Managed Care Contracting

Many health centers are impacted by managed care contracting. Health centers should be able to demonstrate that they have engaged in an assessment of the adequacy of the reimbursement for the specific range of services included in their contracts. The appropriate systems should be in place to manage the risk associated with the contracts. The health center should also have implemented activities related to responsibilities for utilization management and/or quality improvement activities for which it will be held accountable.

These responsibilities should be clearly stated in the contract or other agreement. Health centers should have in place data systems for the collection of required types of data, the sharing of information with managed care organizations and the initiation of utilization management and quality improvement activities.

4. Management Systems

a. Information Management

The quality of every decision made in health centers is critically dependent upon the availability of accessible, accurate, relevant and current information. Information management defines a strategy for getting the right information into the hands of the decision-maker at the right time, whether for care delivery, health care access coordination, internal monitoring, quality assurance and improvement, financial management, risk management, or management decisions and planning.

An information management strategy establishes the policies and procedures for data collection, organization, storage, maintenance (including backups), security, presentation (displays and reports), and communication and exchange with other organizations.

The policies and procedures cover all formats of data, from charts, notes and images, to all forms of electronic storage.

Health centers must have systems in place which accurately collect and organize data for required reporting of program related statistics, as well as for internal monitoring, quality improvement and the support of management decisions and planning.

The health center should be able to integrate clinical, administrative, and financial information to allow monitoring of the operations and status of the organization as a whole. Ability to collect and analyze service data based on Current Procedural Terminology (CPT) and International Classification of Diseases (ICD) codes and utilize a system based on relative value units (RVU) to analyze production and costs are considered essential in today's environment. Health centers are expected to utilize information to monitor performance compared to internal and external benchmarks, as well as for tracking trends.

Financial information systems must be capable of tracking, analyzing, and reporting key aspects of the organization's financial status. These include revenue generation by source, billing and collections, cash flow, expenditures (by category or cost center) and unit costs. The system must provide sufficient information to support necessary accounting functions. Financial information systems should be capable of adapting to changing reimbursement mechanisms in the health care marketplace, including prepaid (at risk) contracts, and supporting accounting and monitoring of all reimbursement mechanisms in which the organization participates. Cost information should be collected and reported such that it informs management decisions concerning potential financial arrangements. The health center should secure cost information to determine whether its managed care contracts are profitable.

The information system should also be capable of supporting the health center's clinical operations, both as a provider of

routine, acute, and preventive health and health related services, and in its role as a care manager and coordinator of health care access. The information should be collected and presented in a manner which provides timely and pertinent clinical information to clinicians concerning individual clients, and should feed into the health center's quality improvement and utilization management program. The system must be designed in a way which protects the confidentiality of client information.

Most of the information needs of today's health care providers are best met using electronic (computerized) data systems. Due to the complexity and volume of information required in the modern health care environment, as well as the power of these systems to manage and process data, automated data processing offers most health centers significant advantages in terms of the efficiency and effectiveness of meeting its information needs. Health centers are encouraged to employ computerized data technology wherever practical given the organization's size, resources, and the nature of services provided. Timely access to information and the capacity to communicate and network with other providers and appropriate agencies and organizations are critical for survival in the information age. Computer systems should be designed to provide Internet access for all appropriate management and clinical staff.

b. Risk Management

The health center must have risk management policies and procedures in place. Such policies and procedures should proactively identify, and plan for, potential and actual risks to the health center in terms of its facilities, staff, clients, financial, clinical and organizational well-being. Risk management policies and procedures should include statements concerning quality assurance and improvement, fire and life-safety, regulatory compliance, and other potential areas of liability. They should also address issues of bonding, insurance, and professional and general liability. Risk management protocols must be incorporated in health center policies to assure that appropriate standards of care and clinical guidelines are established and followed. These protocols must be reviewed and revised. Periodic training in risk management and yearly continuing education is necessary for all providers of primary care services to assure that quality is maintained and improved. Health centers should explore participation in professional liability coverage available to them under the Federal Tort Claims Act.

5. Financial System

At a minimum, health center programs must maintain financial systems which provide for internal controls, safeguard assets, ensure stewardship of federal funds, maintain adequate cash flow to support operations, assure access to care, and maximize revenue from non-federal sources. Financial systems should be routinely reviewed and updated to assure that the organization remains financially sound, competitive, and attuned to changes in the local, state, and national health care environment.

a. Accounting and Internal Controls

Health centers must have accounting and internal control systems appropriate to the size and complexity of the organization. An accounting system, based on Generally Accepted Accounting Principles (GAAP), must be in place and designed to accurately reflect the financial performance of the organization. Within the constraints of organizational and staff size, separation of financial functions should be implemented to safeguard assets.

A set of routine financial reports must be generated and reviewed by appropriate management staff and members of the health center's governing body on a regular basis. Reports will vary depending on organizational size, complexity, and services, but should reflect the current financial status of the health center and allow for comparisons to past and projected financial position.

b. Budget

The budget is the culmination of negotiations among health center managers, clinicians, and board members as they determine the level and scope of services to be provided within the constraints of the organization's resources. The budget, as part of the health center's operating plan, must attempt to accurately project both the resources available in the coming budget period and the expenditures required to achieve the health center's goals and objectives. The annual operating budget must be approved by the board.

In order to realistically project revenues and expenses, health centers should be able to draw upon past budgetary experience and to identify significant changes anticipated in the coming period, both internally and in the health care marketplace in which the organization operates. The health center's managers should pay careful attention to changes in the centers's key sources of revenue, including all federal, state, local, and private sources of grant and service-based funding. Particular attention should be focused on changes in the state Medicaid system. Changes in the level and mechanism of Medicaid

reimbursement and enrollment criteria can have significant impacts on the reimbursement to the health center and on the level and type of demand it experiences. The health center's budget should be reviewed regularly by appropriate members of the health center's management and governing board, and adjustments made as necessary.

c. Billing and Collections

Health centers must provide access to services without regard for a person's ability to pay. Given the limited availability of federal resources, an important component of fulfilling this mandate is the maximization of revenue from all sources. Revenue maximization requires an adequate and competitive fee schedule and a corresponding schedule of discounts, prompt and accurate billing of third party payers, billing of patients in accordance with the schedule of discounts, and timely follow-up on all uncollected amounts. Participation in insurance programs used by the health center's population is of critical importance, as is assuring that reimbursement under such arrangements is adequate to cover the costs of services provided. Health centers must maximize revenue and participate in favorable enhanced or cost-based reimbursement programs for which they are eligible.

Billing of clients without insurance, collection of co-payments and minimum fees, and screening for financial status, must be done in a culturally appropriate manner to assure that these important administrative steps do not, themselves, present a barrier to care. This aspect is particularly important for organizations working with special populations facing particular socio-economic barriers. The steps outlined should not conflict with the mission and mandate of health center programs, but rather assure that the federal grant resources available to the organization are used to address true financial access barriers to the maximum degree possible.

Health centers must have written, board approved, billing, credit, and collections policies and procedures which, at a minimum, include: a fee schedule for all billable services covering reimbursable costs and comparable to prevailing local rates; a method of discounting or adjusting fees based upon the patient's income and family size from current Federal Poverty Guidelines; and, a system of billing patients and third-party payers within a reasonable period of time after services are provided, typically within 30 days. Health centers should establish a target for days in receivables for collections on billable services by payer, monitor collection rates on outstanding balances and follow-up or write-off such balances as appropriate. Where possible, health centers are encouraged to

utilize electronic systems for billing and insurance verification.

Health centers participating in prepaid plans should have a system in place to receive timely notification of enrolled members, and to tie receipts of capitation payments to enrolled members regardless of utilization of services. Health centers are encouraged to develop expanded fee schedules to reflect the costs associated with non-billable services provided to patients. Health centers also should establish policies and procedures for out-of-plan services for capitated patients, and for required pre-authorization of services and referrals to patients based on managed care contractual agreements. To the extent that health centers are at risk for services performed outside their facilities, 'Incurred But Not Reported' (IBNR) expenses -- the unpaid cost of services already provided to a plan member -- must be tracked carefully as a liability that can threaten the financial stability of a health center. These steps will help assure that health centers can remain viable and provide ready access to care for all patients in light of changing marketplace pressures.

d. Independent Financial Audit

Health centers must ensure that an annual independent financial audit is performed in accordance with federal audit requirements. Audits on non-profit health centers must follow the most recent federal guidelines pertaining to the auditing of non-profit institutions and, specifically, to the auditing of recipients of federal awards to such institutions. Health centers should issue a memorandum of engagement for an annual independent financial audit, which will be performed in compliance with the applicable federal guidelines. In addition, the Financial Status Report (FSR) and reconciliation between the audit and FSR must be prepared.

The audit report must provide an opinion, in writing, on the scope of the audit, the fairness of the grantee's financial statements, and an evaluation of the organization's system of internal accounting controls. The auditor shall determine whether the health center is operating in accordance with Generally Accepted Accounting Principles, and should provide the grantee with an opinion on their findings. Where significant audit exceptions and/or internal accounting control findings exist, the health center must implement a time-phased corrective action plan and may be subject to grant award conditions.

6. Facilities

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The site(s) at which the health center delivers its services to clients are central to the image and acceptability of the health center to the clients, the staff, and the community. The appearance, layout, and location of facilities have implications for access, efficiency, quality, recruitment, and reimbursement in terms of participation in closed panel payer arrangements. Facilities used by health center programs should be appropriately located to promote access by its target population, adequate in size and layout to provide the services located there, and designed to promote the delivery of high quality, effective, and efficient health services and related services in a safe environment. Facilities owned or leased by a health center must conform to fire and life safety codes, handicapped access codes, and applicable building codes and regulations.

The health center should assure that any facility it uses is adequately insured, and should manage its facilities to ensure cleanliness, security, and routine maintenance and repair. The health center should plan for its facilities and major equipment needs for the foreseeable future and make arrangements for procuring needed capital and other resources to meet those needs.